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Briefing Report to the Chairman, Committee on Appropriations, House of Representatives

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MEDICARE

Contractor Services to Beneficiaries and Providers

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ORIGINAL

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United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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March 16, 1988

The Honorable Jamie L. Whitten
Chairman, Committee on Appropriations
House of Representatives

Dear Mr. Chairman:

The July 30, 1987, report accompanying the fiscal year 1988 appropriations bill for the Departments of Labor, Health and Human Services, and Education, and Related Agencies, requested us to determine the level of beneficiary and provider satisfaction with the administrative services received under the Medicare program. We agreed with Committee staff to examine and report on the changes that occurred from fiscal years 1983 through 1987 in the timeliness and accuracy of claims processing, the responsiveness to beneficiary and provider inquiries, and the processes available to beneficiaries and providers to dispute decisions about reimbursement and program coverage. Our report also presents the views of various officials responsible for the Medicare program and provider groups and organizations representing the elderly on the services provided under the Medicare program.

BACKGROUND

The Medicare program provides two types of health insurance to about 32 million beneficiaries. Part A covers hospital, nursing home, and home health agency services, while Part B covers physician, outpatient, and certain other medical services and supplies. Although the Health Care Financing Administration (HCFA) in the Department of Health and Human Services administers the Medicare program, it relies on contractors to process and pay Medicare claims. In fiscal year 1987 the contractors--fiscal intermediaries under Part A and carriers under Part B--paid $48.0 billion in Part A benefits and $28.7 billion in Part B benefits. Intermediaries pay outpatient claims even though outpatient care is covered under Part B.

In addition to paying claims, contractors provide other services to beneficiaries and providers--namely, responding to written, telephone, and walk-in inquiries; providing claims dispute processes; and educating beneficiaries and providers about program benefits and requirements. HCFA monitors contractor performance through annual contractor evaluations.

The following presents claims and cost information for fiscal years 1983 through 1987.

Number and Cost of Claims Processed

	Fiscal year				
	1983	1984	1985	1986	1987
Claims processed:					
Part A (in millions)	50.6	50.0	58.6	64.4	67.4
Part B (in millions)	207.7	226.2	267.2	298.8	338.3
Administrative costs (in millions)	NA	$815.3	$922.0	$971.8	$1,011.0
Processing cost per claim:					
Part A	$2.45	$2.64	$2.33	$1.97	$1.81
Part B	2.05	2.04	1.88	1.72	1.65

NA = Not Available

RESULTS IN BRIEF

Claims processing times increased each year from fiscal year 1983 through 1986, with the longest times generally occurring in fiscal years 1985 and 1986. According to contractor officials, program and policy changes, such as implementing a common claims coding system, and HCFA's directive to increase the average number of claims awaiting processing (pending claims), accounted for the increase in average processing times during these 2 fiscal years. HCFA's directive was intended to achieve Gramm-Rudman-Hollings budget reductions by delaying claims payments.

Claims processing times improved in fiscal year 1987. Beginning in fiscal year 1987, HCFA placed increased emphasis on timeliness during its annual contractor performance evaluations because of the claims processing times required by the Omnibus Budget Reconciliation Act of 1986. HCFA also provided contractors an additional $41 million in fiscal year 1987 to process the increase in claims volume and to meet the requirements of the act. We were told by HCFA and contractor officials that these were the reasons for the improved performance.

From fiscal years 1983 through 1985, the accuracy of carriers' claims processing decreased. During fiscal year 1985, both the frequency of contractor clerical errors and the average amount of an error reached their highest rates--a 6.7-percent

frequency rate and a 1.8-percent payment error rate. Both rates decreased during fiscal year 1986--the most recent fiscal year data available--to 6.4 percent for frequency and 1.6 percent for payment errors. Both rates were still slightly higher than the 1983 rates.

Carrier review of appealed claims cases and processing of hearings related to appealed claims followed the same trend. Carriers had a greater portion of cases waiting for review 60 days or more at year end and a greater portion of hearings cases pending 120 days or more at year end for each fiscal year from 1983 through 1986. In fiscal year 1987 performance improved.

Other contractor services to beneficiaries and providers include responding to written, telephone and walk-in inquiries. Total beneficiary and provider inquiries increased under both Parts A and B between fiscal years 1986 and 1987. For fiscal years 1986 and 1987, inquiries per 1,000 claims received under Part B and beneficiary inquiries under Part A generally held constant, while Part A provider inquiries increased from 12 to 22 per 1,000 claims.

When a written response is needed, HCFA standards require contractors to respond to 95 percent of such inquiries within 30 days. In fiscal year 1985, 93 percent of the intermediaries and 65 percent of the carriers evaluated met this standard. In fiscal year 1986, contractor performance under this standard dropped; 66 percent of the intermediaries and 64 percent of the carriers evaluated met the standard. Fiscal year 1987 data were not available at the time of our review.

Telephone service for beneficiaries under Part B improved during calendar year 1987--the first year new telephone monitoring equipment was operational. As a result of agreements reached as part of a lawsuit filed by a senior citizen advocacy group against the Secretary of Health and Human Services, HCFA increased the emphasis on contractor telephone responsiveness during its fiscal year 1987 contractor performance evaluations. By December 1987, nearly all the carriers were meeting HCFA's standard, which specifies that no more than 20 percent of the callers to a carrier receive a busy signal. In addition, about 90 percent of all callers waited no more than 2 minutes to talk with a carrier representative.

Contractors also are responsible for educating beneficiaries and providers about Medicare coverage and requirements. Contractor and HCFA officials and organizations representing the elderly and providers agreed that program education efforts have deteriorated over the past few years. Officials at 11 of the 12 contractors we contacted stated that principally because of funding limitations, they offer fewer workshops and produce fewer bulletins about program changes. Representatives of several organizations representing the elderly and provider groups stated that the growing complexity of the Medicare program calls for greater education efforts, not less.

Changes in
Selected Performance Measures
for the Medicare Program

Measure of performance	Change in performance from previous fiscal year 1984	1985	1986	1987
Average time to process:				
Part A inpatient claims	-	-	-	+
Part A outpatient claims	-	-	-	+
Part B total claims	-	-	-	+
Percent of Part B claims processed within 30 days	-	-	-	+
Percent of claims pending to total processed at year end:				
Part A claims	-	-	+	+
Part B claims	-	-	-	+
Part B error rates:				
Frequency	-	-	+	NA
Amount	-	NC	+	NA
Percent of Part B reviews pending 60 days or more	-	-	-	+
Percent of Part B hearings pending 120 days or more	-	-	-	+

(-) Denotes decreased performance from prior year
(+) Denotes improved performance from prior year
NA Not available
NC No change in performance from prior year

In summary, contractor performance improved overall during fiscal year 1987, following several years of decreasing performance. Whether this improved performance will be

sustained, given an increasing number of claims, is unclear at this time. Also unanswered is whether the decreased claims processing times in fiscal year 1987 have come at the expense of accuracy. Fiscal year 1987 error rate information was not available at the time of our review. Although the reasons we were given for the improved fiscal year 1987 performance varied, the principal reasons offered by HCFA and contractor officials for decreased claims processing times and the reduced number of pending claims at year end were Omnibus Budget Reconciliation Act of 1986 requirements, HCFA's increased emphasis on processing times during its contractor evaluations, and additional claims processing funds provided by HCFA to the contractors. Likewise, improvements in beneficiary telephone service were attributed to HCFA's emphasis on this service during its evaluations.

SCOPE AND METHODOLOGY

We did our work at HCFA's headquarters in Baltimore and at its regional office in Boston. We obtained HCFA statistical data, when available, for fiscal years 1983-87 relating to claims processing costs, workload, timeliness, and errors as well as information on beneficiary and provider inquiries and appeals. We interviewed officials at six intermediaries and six carriers located throughout the country to obtain information and their views on services provided to program beneficiaries and providers. We selected the contractors on the basis of their claims workload, their performance, and their geographic location. We also contacted seven organizations representing the elderly and eight representing providers to obtain their views on the services received under the Medicare program.

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As requested by your office, we did not obtain formal agency comments on this report. However, HCFA officials informally reviewed the report, and we have incorporated their comments where appropriate. Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issuance date. At that time, we will send copies to other congressional committees having jurisdiction over the matters discussed in the report, the Secretary of Health and Human Services, and other interested parties.

If you have any questions, please call me on (202) 275-6195.

Sincerely yours,

Michael Zimmerman
Senior Associate Director

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Abbreviations

HCFA	Health Care Financing Administration
HHA	home health agency
MBS	Massachusetts Blue Shield
OBRA	Omnibus Budget Reconciliation Act of 1986
SNF	skilled nursing facility
SSA	Social Security Administration

MEDICARE: CONTRACTOR SERVICES TO BENEFICIARIES AND PROVIDERS

INTRODUCTION

Medicare is a federal program authorized by title XVIII of the Social Security Act (42 U.S.C. 1395). The program pays for much of the health care costs for eligible persons age 65 or older and certain individuals under 65 who are disabled or have chronic kidney disease. The Health Care Financing Administration (HCFA), in the Department of Health and Human Services, administers the program.

Medicare consists of two types of insurance, Parts A and B. Part A, Hospital Insurance for the Aged and Disabled, covers services furnished primarily by hospitals, home health agencies (HHAs), and skilled nursing facilities (SNFs). Part A is financed primarily by taxes on earnings paid by employers, employees, and self-employed persons. During 1987,[1] Medicare paid $48.0 billion in Part A claims and had about 32 million eligible beneficiaries.

Medicare Part B, Supplementary Medical Insurance for the Aged and Disabled, covers physicians' services, outpatient hospital care, and other medical services and supplies. Part B generally covers 80 percent of the approved charges[2] for services, subject to a $75 annual deductible. Enrollment is voluntary. Part B is financed by appropriations from general revenues, which cover 75 percent of program costs, and by beneficiaries' monthly premium payments, which cover the other 25 percent. In 1987, Medicare Part B covered about 32 million beneficiaries and paid $28.7 billion in claims.

HCFA administers the Medicare program through a network of contractors that process claims, make payments, and provide various other services to beneficiaries and providers. Contractors under Part A are referred to as intermediaries;[3]

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[1]Unless otherwise indicated, all references to years refer to fiscal years.

[2]The approved charge is the lowest of (1) the actual charge (billed amount) for the service, (2) the customary or most frequent charge for a service by a provider, or (3) the prevailing charge based upon the customary charges in the local area for the service.

[3]In addition to processing and paying inpatient hospital claims, intermediaries also process and pay claims for hospital outpatient services, which are covered under Part B. We include outpatient claims under Part A throughout the report as HCFA compiles information this way.

those under Part B are called carriers. In 1987, 44 intermediaries processed about 67 million Part A claims, while 47 carriers processed about 330 million Part B claims.

Under Part B, claims may be assigned or unassigned. All Part A claims are assigned. If a claim is assigned, the provider submits it to the contractor for payment and agrees to accept the contractor's determination of the approved charge. The beneficiary remains responsible for any coinsurance, which is the percentage of the approved charge for covered medical expenses a beneficiary pays, and the deductible, which is the covered medical expenses a beneficiary must pay before Medicare pays. If the claim is unassigned, the beneficiary submits it to the contractor, which pays the beneficiary directly. The beneficiary pays the provider and is responsible for the coinsurance amount, any unmet deductible, and any difference between the provider's actual charge and the Medicare-approved charge.

Contractor Services

Contractors are responsible for reimbursing Medicare beneficiaries and providers in a timely and accurate manner. Contractors routinely perform certain edits and screens on the claim, such as determining the person's eligibility, unmet deductible amounts, and whether the service is covered and calculating the Medicare-approved charge for a service. If the claim passes the edits and screens, payment is made, less any unmet deductible and coinsurance amounts; otherwise, it is denied or suspended. A suspended claim needs additional information from the beneficiary or provider before it can be paid.

Contractors also provide other services to beneficiaries and providers, such as responding to inquiries, handling appeals, and offering program education services. Beneficiaries and providers may write, telephone, or walk in to a contractor's office with questions about program coverage, the status of claims submitted, or amounts paid. Contractors are responsible for answering inquiries in a timely and accurate manner. Any beneficiary or provider that is dissatisfied with a contractor's coverage decision or payment amount may dispute it and request the contractor to review the decision. If still dissatisfied, generally the beneficiary or provider may request a hearing before an administrative law judge under Part A or a hearings officer under Part B. Contractors also provide educational services about the Medicare program to beneficiaries and providers. Educational services can consist of newsletters, workshops, and visits to providers and beneficiary groups.

OBJECTIVES, SCOPE, AND METHODOLOGY

The July 30, 1987, report accompanying the 1988 appropriations bill for the Departments of Labor, Health and

Human Services, and Education, and Related Agencies requested us to determine the level of beneficiary and provider satisfaction with the administrative services received under the Medicare program. We agreed to examine and report on the changes occurring from 1983 through 1987 in the (1) timeliness and accuracy of claims processing, (2) responsiveness to beneficiary and provider inquiries, and (3) various processes available to beneficiaries and providers to dispute decisions about reimbursement and program coverage. To accomplish the objective, we obtained and analyzed HCFA data from 1983 through 1987. We also met with HCFA officials, contractor officials, and officials of organizations representing the elderly and provider groups to obtain their views related to our three areas of inquiry.

Appendix I identifies the six Part A intermediaries and six Part B carriers we selected to discuss claims processing timeliness and accuracy, and beneficiary and provider services. Appendix I also lists the seven organizations representing the elderly and eight representing provider groups from whom we obtained opinions. We obtained limited information from these groups as only one had surveyed its constituents on contractor services.

We selected the 12 contractors based on a combination of factors: overall contractor performance evaluation program[4] efficiency ratings for 1986 and contractor size in terms of the number of Medicare claims processed in that year. We also made our selections to obtain a mix of small, medium, and large contractors in different geographic locations across the country whose performance evaluation scores for 1986 placed them in approximately the top or bottom third of their peers.

Our selection was heavily weighted toward Blue Cross and Blue Shield organizations since, in 1987, they processed about 88 percent of Part A claims and 64 percent of Part B claims. We also met with Blue Cross and Blue Shield Association representatives in Chicago.

Claims Processing Times

To assess claims processing timeliness, we obtained HCFA statistical data for 1983-87 on (1) the number of claims processed and pending, i.e., awaiting processing; (2) average processing times; (3) the number of electronically transmitted

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[4]HCFA conducts an annual evaluation designed to improve contractor effectiveness and efficiency. Under the program, HCFA develops measurement standards, evaluates performance against the standards, identifies deficient areas, and follows up on corrective actions taken by the contractors.

claims[5] received by contractors; and (4) assignment rates. We also obtained administrative cost data from HCFA for 1984-87. Comparable data were not available for 1983. We met with HCFA officials to discuss claims processing times and how they monitor and evaluate contractor performance. We also met with officials from selected contractors to discuss claims processing times and the factors that can influence them. In addition, we reviewed pertinent sections of the Omnibus Budget Reconciliation Act of 1986 (OBRA).

Claims Processing Accuracy

To assess claims processing accuracy, we obtained statistical data for 1983-86 from HCFA relating to both the frequency and dollar amounts of Part B errors. The data for 1987 were not available at the time of our review. Similar information is not collected for Part A.

Beneficiary and Provider Inquiries

To determine changes in and contractor responsiveness to beneficiary and provider inquiries, we obtained statistical data from HCFA covering the number of telephone, written, and walk-in inquiries received during 1986 and 1987. We used HCFA statistical reports for calendar year 1987 to determine contractor responsiveness to telephone inquiries. Before this time, contractor telephone measuring equipment was not installed. We also obtained performance evaluation results for 1985 and 1986 to determine contractor written responsiveness to inquiries. Because HCFA changed this standard in 1984, we began our evaluation with 1985; comparable data for 1987 were not available.

Beneficiary and Provider Appeals

To measure changes in the number of beneficiary and provider appeals, we obtained HCFA data on the number of appeals cleared for the 5 fiscal years covered by our review and the results of the appeals. We also reviewed data on the timeliness of carrier responses to appeals filed by beneficiaries and providers for the same years.

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[5]Claims that are machine readable when received by the contractor generally are processed faster and at less cost than paper claims since they can be read directly into the contractor's claims processing computer system.

Contractor Education Efforts

To assess contractor public education efforts, we met with officials at the selected contractors and inquired about changes in the level of effort devoted to this area from 1983 through 1987. We also discussed this topic with HCFA officials and organizations representing the elderly and the providers.

Reliability of the Data

At one carrier we validated the accuracy of statistical data concerning claims processing times supplied by contractors to HCFA. (See app. II for a description of the methodology used and the results obtained.) We did not assess the reliability of other data furnished to HCFA by contractors or HCFA data supplied to us, as time did not permit. In our discussions with officials from the contractors included in our review, however, we asked if they had detected discrepancies in the type of data we were using. None of the officials indicated that HCFA's reproduction of their data was inaccurate.

We conducted our work from September 1987 through February 1988. As requested by Committee staff, we did not obtain agency comments on this briefing report. However, we discussed its contents with HCFA officials and have incorporated their comments where appropriate. Our work was performed in accordance with generally accepted government auditing standards.

BACKGROUND

The number of claims processed and the amount of funds HCFA provides contractors for their Medicare program operations influence claims processing times and the quantity and quality of other beneficiary and provider services. The number of claims processed increased significantly from 1983 through 1987 for both parts of the program. From 1984 to 1987, administrative costs[6] for the Medicare program increased each year; however, the average cost to process a claim decreased under both program parts.

Number of Claims

From 1983 through 1987, the number of Part A claims processed increased by 33 percent, while Part B claims processed increased by 63 percent. HCFA and contractor officials attribute this increase to several reasons, including an increased number

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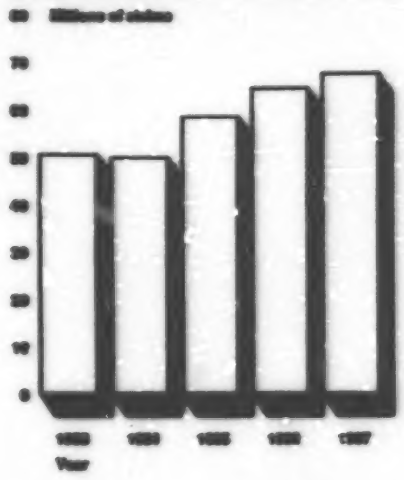
[6]Administrative costs include costs for claims processing, beneficiary and provider services, and payment safeguard activities, such as medical reviews and audits.

of beneficiaries and an increase in claims for certain types of services, such as outpatient and laboratory.

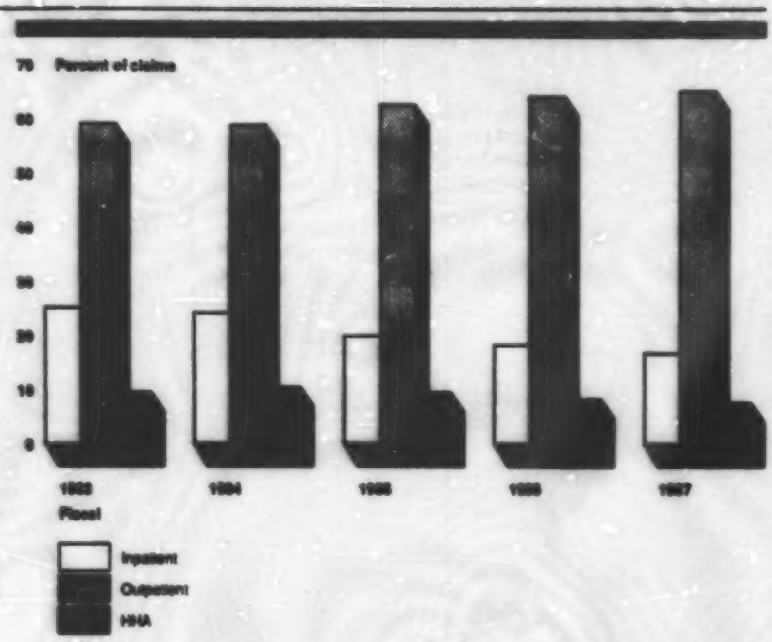
The number of Part A claims processed from 1983 through 1987 increased from 50.6 million to 67.4 million, representing an 8.3-percent average annual increase. Figure 1 shows a slight decrease in claims processed between 1983 and 1984 followed by increases during the next 3 years.

Figure 1: Part A Claims Processed (1983-87)



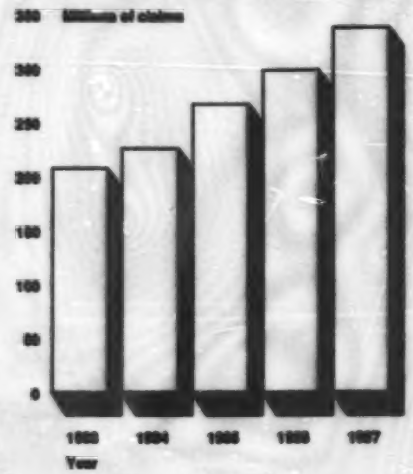
Outpatient claims, which represent the largest percentage of Part A claims, have increased as a percentage of total Part A claims processed during 1984-87. Inpatient claims have decreased as a portion of Part A claims processed. Figure 2 shows the percentage of inpatient, outpatient, and HHA claims processed during the same period. We have not included SNF claims in the figure because they account for less than 2 percent of the Part A claims processed in each of the 5 years covered in our review. Similarly, we have not included certain other claims, such as those from rural health clinics.

Figure 2: Part A Claims Processed, by Type of Claim (1983-87)



The number of Part B claims processed (figure 3) increased from 207.7 million in 1983 to 338.3 million in 1987, or an average annual increase of 15.7 percent. The increase in the number of claims during each year has been steady.

Figure 3: Part B Claims Processed (1983-87)



HCFA officials and officials of the 12 contractors contacted during our review attributed the increased claims volume under both parts of the program to

-- an increase in the number of program beneficiaries;

-- an increase in the number of physicians accepting assignment, which leads to more frequent submissions of Part B claims; and

-- an increase in claims for laboratory, outpatient, and ambulatory services.

Program Administrative Costs

Total program administrative costs have increased annually from 1984 through 1987. The total program administrative cost for 1983 was not available. The cost per claim, however, has been reduced significantly since 1983. Tables 1 and 2 show program administrative costs for 1984-87 and the national average processing cost per claim for Parts A and B for 1983-87.

Table 1: Program Administrative Costs

Dollars in thousands

Year	Program administrative costs
1984	$ 815,250
1985	921,953
1986	971,755
1987	1,010,964

Table 2: National Average Cost Per Claim

Year	Part A	Part B
1983	$2.45	$2.05
1984	2.64	2.04
1985	2.33	1.88
1986	1.97	1.72
1987	1.81	1.65

Administrative costs, as a percentage of total program expenditures, have remained steady for 1985-87 at 1.3 percent.

CLAIMS PROCESSING TIMES AND ACCURACY

Claims processing times increased each year from 1983 to 1986 for both Part A and Part B claims but decreased in 1987. For example, it took intermediaries an average of about 14 days

to process a Part A inpatient claim during 1986 and about 10 days during 1987.

Also, in 1987, despite a 13.2-percent increase in claims volume, carriers significantly reduced the inventory of pending claims and processed an increased percentage of claims within the first 30 days of receipt. Except for Part A outpatient claims, however, the time to process Part A and Part B claims was longer in 1987 than in 1983.

According to HCFA and contractor officials, factors that tended to increase claims processing times during these 5 years included the increase in claims and program and policy changes initiated by HCFA. Factors that tended to decrease claims processing times, according to these same officials, were increases in the percentage of electronically transmitted claims received; assignment rate increases, which result in a greater percentage of error-free claims since providers submit more accurate claims than beneficiaries; the claims processing time requirements of OBRA; and additional claims processing funds.

Carrier accuracy in processing Part B claims decreased between 1983 and 1985. HCFA evaluations show that during this period error frequency ranged from 6.1 percent in 1983 to 6.7 percent in 1985, while error amounts ranged from 1.5 percent in 1983 to 1.8 percent in 1984 and 1985. Carriers improved their performance in 1986 and lowered their frequency error rate to 6.4 percent and their payment error rate to 1.6 percent. Since error rate data for 1987 were not available, it is uncertain whether carriers continued to improve their performance or whether error rates increased as carriers lowered their average processing times.

Claims Processing Times

Intermediary claims processing times for inpatient and outpatient claims increased each year from 1983 to 1986 but then decreased in 1987. However, it took longer to process an inpatient claim in 1987 (10.3 days) than it did in 1983 (5.5 days) while it took less time in 1987 (6.7 days) to process an outpatient claim than it did in 1983 (7.3 days). Carrier processing of Part B claims followed the same trend; increases in claims processing times for each year between 1983 and 1986 followed by improved performance in 1987. It still took carriers longer to process a claim in 1987 (12.9 days) than it did in 1983 (9.9 days).

The average processing times for 1983-87 are shown in figures 4 and 5. Parts A and B are shown separately. Figure 4 shows the average processing times for inpatient and outpatient claims, which accounted for about 82 percent of all Part A claims during the 5 years covered in our review. Since all Part A

claims are assigned, we did not differentiate between assigned and unassigned claims. Figure 5 shows Part B processing times for assigned and unassigned claims and for total claims processed.

An important item to note is that HCFA changed its definition of claims processing time. Before 1987, average processing time covered the period from when the claim was received by the contractor to when it was adjudicated. Starting in 1987, the definition was changed to reflect the longer interval between the date the claim was received and when the payment or denial notice was mailed. Given this change, the 1987 improved performance is even more significant.

Figure 4: Part A Average Claims Processing Time (1983-87)

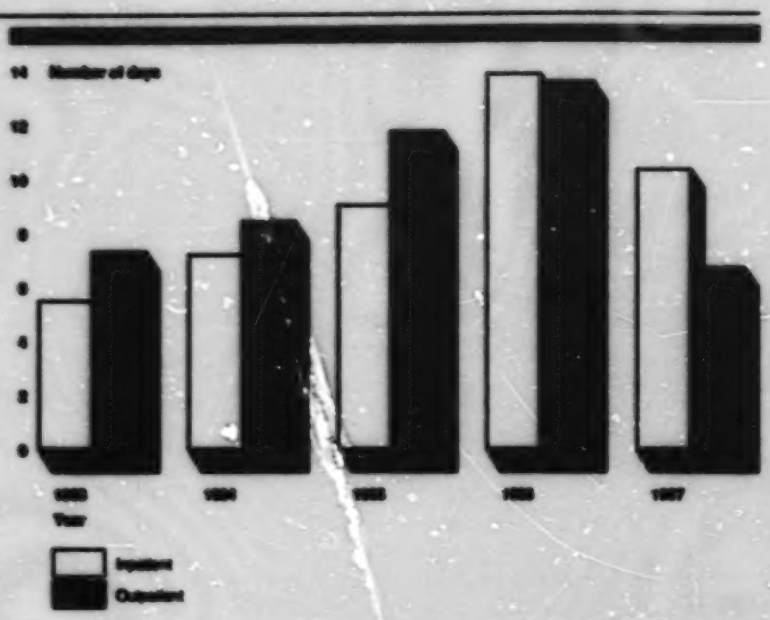
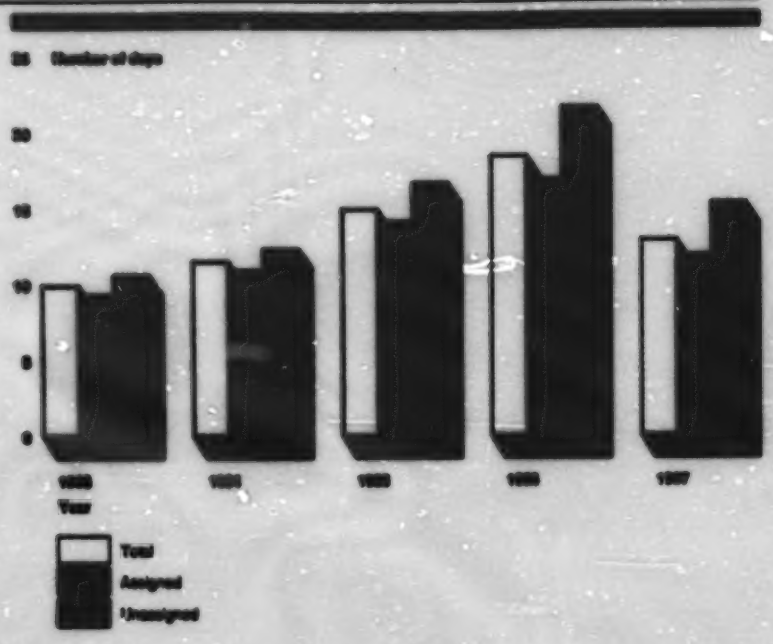


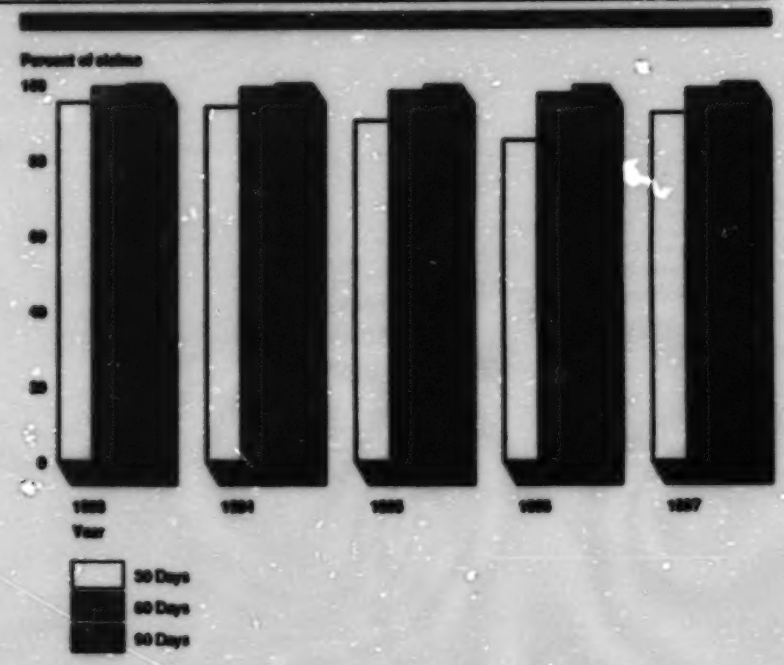
Figure 6: Part B Average Claims Processing Time (1983-87)



Part B Claims Processed in 30, 60, and 90 Days

HCFA compiles information showing the percentage of Part B claims processed by carriers within 30, 60, and 90 days of receipt. Similar information is not compiled for Part A claims. Figure 6 shows that the percentage of claims processed within 60 and 90 days remained about the same, while the percentage of claims processed in 30 days decreased each year from 1983 through 1985 but increased in 1987. While not illustrated in figure 6, quarterly data show that in the fourth quarter of 1987, carriers processed 95.8 percent of the claims received within 30 days, which is the second best quarterly performance in the 5 years included in our review.

Figure 6: Part B Claims Processed in 30, 60, and 90 Days (1983-87)



Claims Pending

The number of Part A claims pending at the end of 1983 was about 857,000, which represented 1.7 percent of the total claims processed during the year. The number of pending claims increased in 1984 and 1985, when it reached over 2 million claims, or 3.5 percent of total Part A claims processed during the year. Both the numbers and percentages decreased in 1986 and 1987, when about 1.3 million claims, representing 2 percent of total claims processed during 1987, were pending.

At the end of 1983, about 4.6 million Part B claims were pending; this represented 2.2 percent of claims processed during the year. By the end of 1985, 10.9 million, or 4.1 percent of the claims processed during the year, were pending. Both the number (8.2 million) and percentage (2.4 percent) of Part B claims pending had been reduced at the end of 1987.

Figures 7 and 8 depict the trends in claims pending for Parts A and B, respectively.

Figure 7: Part A Claims Pending (1993-97)

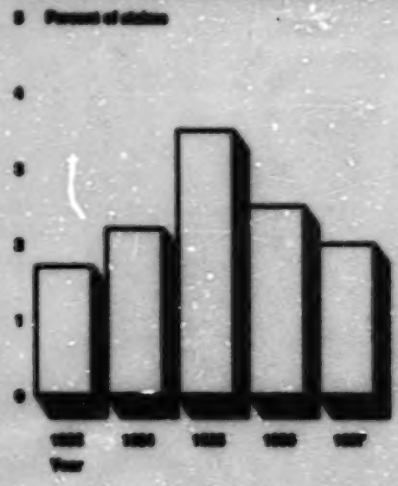
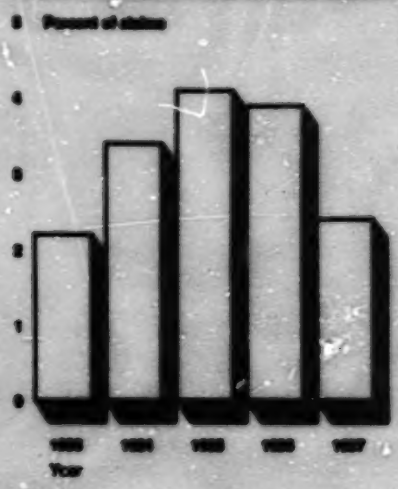


Figure 8: Part B Claims Pending (1993-97)



Effect of Assignment Rates And Electronically Submitted Claims on Processing Time

The percentages of assigned claims and electronically submitted claims affect claims processing times. According to HCFA and contractor officials, an increase in assigned claims results in contractors receiving more error-free claims, which

permits quicker processing. Likewise, an increase in electronic claims also permits quicker processing times since such claims arrive at the contractors ready for direct entry into the computer system.

The assignment rate under Part B increased from 54 percent of total claims in 1983 to 72 percent in 1987. All Part A claims are assigned. Also, electronically submitted claims increased in volume and as a percentage of total claims processed under both Parts A and B. From 1983 through 1987, the percentage of Part A claims submitted electronically increased from 29 to 69 percent, while the Part B percentage increased from 8 to 31 percent.

Effect of Program and Policy Changes on Processing Times

Program and policy changes initiated by HCFA and OBRA, and increased claims processing funding, affected claims processing times for 1985-87, according to contractor and HCFA officials. HCFA required contractors to implement a number of program changes in 1985 which, according to the contractors contacted, increased the time to process claims. In calendar year 1986, HCFA instituted a policy designed to slow claims processing in order to meet budget reduction requirements. In 1987, however, OBRA requirements resulted in HCFA changing 1987 contractor evaluation standards for claims processing and increasing claims processing funds. These actions, according to HCFA officials, lead to the reduced average processing times for the year.

During 1985, HCFA implemented certain program changes that we were told increased contractor claims processing times. These changes included implementing a freeze on the amount of reimbursement provided physicians, changing durable medical equipment lease/purchase requirements, standardizing the explanation of benefit descriptions sent to beneficiaries, and implementing a common coding system for Parts A and B claims.

In 1986 claims processing times increased because of HCFA's directive to delay payments. To help achieve Gramm-Rudman-Hollings budget reduction targets of 4.3 percent, HCFA directed its contractors to approximately double their pending claims inventory. HCFA officials stated that this change effectively increased average payment time from 18-20 to approximately 30 days. The delay in payments also postponed the payment for many claims from one year to the next, according to HCFA officials, thereby decreasing both program expenditures and certain associated claims processing costs for 1987.

In July 1986, HCFA implemented a policy requiring contractors to pay 95 percent of "clean claims"[7] within 27 days after receipt. In September 1986, HCFA provided $14.4 million in additional funds to help carriers and intermediaries meet this new standard.

OBRA set claims processing timeliness standards that became effective in 1987. The act required contractors to pay 95 percent of clean claims within 30 days in 1987, 26 days in 1988, and 25 days in 1989. For carriers, participating physicians'[8] claims are to be paid in 19 days in 1988, 18 days in 1989, and 17 days thereafter. The act also requires that interest be paid to either beneficiaries or providers on clean claims that are not paid within the stipulated time frames.

In response to the OBRA requirements, HCFA established claims processing timeliness standards for its 1987 contractor evaluations. HCFA's standards incorporated the OBRA claims processing requirements. Before this, HCFA had not established standards for specific times for claims processing. Since the newly added claims processing standard is classified as a critical standard, contractors that fail it automatically fail the evaluation regardless of how well they perform in other evaluation areas.

In addition to 1987 contractor evaluation changes, HCFA also released $41 million in additional funds for contractors to process the expected increase in claims and to meet the OBRA requirements.

In 1987, 11 of the 12 contractors we contacted met the 30-day claims processing timeliness standard. To do this, officials stated that they took one or more of the following actions:

-- Added claims processing staff.

-- Changed their monitoring reports to reflect the new claims processing standards.

-- Automated or enhanced their claims processing systems.

-- Wrote checks daily rather than weekly.

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[7]Claims that can be processed without requesting additional information from the beneficiary or provider.

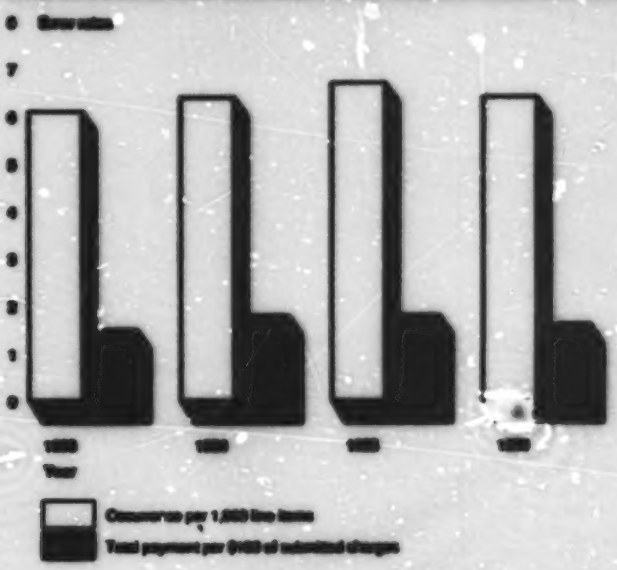
[8]Physicians who agree to accept assignment during a year for all services provided to Medicare beneficiaries.

According to contractor officials, the payment standards for 1988 are more difficult to meet. Of the 11 contractors who responded, 4 of the 5 carriers and 1 of the 6 intermediaries told us they were experiencing problems processing 95 percent of clean claims in 26 days. Conversely, 1 carrier and 5 intermediaries were meeting this standard. One reason that intermediaries are generally more successful in processing clean claims timely is because a greater proportion of their total claims are electronically transmitted. Three carriers told us they were achieving the 19-day standard for participating physicians and three said they were having difficulties meeting this standard.

Carrier Claims Processing Error Rates

Carrier errors during claims processing are measured in two ways--occurrence (frequency) and over- and underpayment amounts. The errors are often detected during quality assurance reviews performed by the carriers using HCFA standards. The quality assurance reviews are monitored by HCFA officials. Occurrence errors, such as entering an incorrect procedure code, coding the claim as assigned when it is unassigned, or entering an incorrect reimbursement rate, are created during claims processing. The occurrence error rate represents the estimated frequency of errors per 1,000 line items. A payment error is when (1) the beneficiary or provider is over- or underpaid, (2) a claim is incorrectly approved or denied, (3) an incorrect amount is applied to the deductible, or (4) an amount that should be applied to the deductible is not. The rate is the estimated dollar amount paid in error per $100 in submitted charges. All payment errors represent occurrence errors, according to a HCFA official.

The accuracy of Part B carrier claims processing decreased from 1983 through 1985 but improved in 1986. Information for 1987 was not available; therefore, it is uncertain whether carriers continued to improve their performance or whether error rates increased as carriers decreased their average claims processing time. The average annual occurrence error rate during the 4-year period ranged from a low of 6.1 percent in 1983 to a high of 6.7 percent in 1985--a 10-percent difference. The average annual occurrence error rate for the 4 years was 6.4 percent. Annual over- and underpayment error rates ranged from 1.5 to 1.8 percent, a 20-percent difference, and averaged 1.7 percent. Figure 9 shows carrier error rates for 1983-86.



BENEFICIARY AND PROVIDER SERVICES

In the area of written responses to beneficiary inquiries, a smaller percentage of contractors between 1985 and 1986 responded in writing to at least 95 percent of their inquiries within 30 days. Carrier telephone services, however, improved. Carrier telephone services available to beneficiaries had deteriorated for a few years before calendar year 1987. In 1986 HCFA introduced stricter performance standards, and telephone services to beneficiaries improved from January 1987 to December 1987. For instance, in January, 20 percent of toll-free callers were waiting longer than 120 seconds to talk with a carrier representative, while in December, 8 percent were waiting longer than 120 seconds.

In 1987, carriers reduced the percentage of review cases pending 60 days or more, for the first time since 1983. Likewise, carriers significantly reduced the percentage of hearings pending 120 days or more, interrupting an upward trend that had existed since 1983.

According to contractor and HCFA officials, education efforts have been deteriorating for the past few years. Contractors and HCFA have not had enough funds to provide needed education about the program to beneficiaries and providers. However, starting in April 1987 HCFA sent a handbook to new enrollees in the Medicare program, but such enrollees represent a small percentage of total Medicare enrollees.

Beneficiary and Provider Inquiries

Between 1986 and 1987, the only 2 years that HCFA compiled statistics for beneficiaries and providers separately, the total inquiries received increased. When analyzed by the number of inquires per 1,000 claims received, however, almost all of the increase resulted from Part A inquiries. Table 3 shows the number of inquiries under Parts A and B.

Table 3: Beneficiary and Provider Inquiries

Numbers in thousands

	Part A intermediaries		Part B carriers	
	1986	1987	1986	1987
Beneficiary	1,502 (23)	1,571 (23)	14,766 (49)	16,204 (48)
Provider	776 (12)	1,498 (22)	5,674 (19)	6,583 (20)
Total	2,278 (35)	3,069 (46)[a]	20,440 (68)	22,787 (68)

Note: Figures in parentheses represent the number of inquiries per 1,000 claims received.

[a]The figure does not add due to rounding.

Under Part A, the total number of inquiries rose by 35 percent in 1987, with 91 percent of the increase from providers. In 1986 provider inquiries represented about a third of the total inquiries intermediaries received. By 1987, provider inquiries constituted almost 50 percent of the total. A breakdown of the 46 inquiries per 1,000 claims received under Part A in 1987 shows 28 telephone inquiries, 17 written inquiries, and 1 walk-in.

Part B inquiries rose by 11 percent from 1986 to 1987; this is the same percentage increase experienced in the number of Part B claims received. The 68 inquiries per 1,000 claims received in 1987 consisted of 51 telephone, 16 written, and 1 walk-in.

According to contractor officials, the possible reasons for the increase in the number of inquiries were

-- claims payment cycle changes,

-- benefit and reimbursement coverage changes,

-- increased number of toll-free and local telephone lines, and

-- reduced funding for beneficiary and provider educational services.

Timeliness of Written Responses

The timeliness of written responses to beneficiary inquiries--telephone, written, or walk-in--has been a contractor evaluation standard since at least 1982, although the standard has changed periodically. HCFA now requires that 95 percent of written responses be made within 30 days of receipt of the inquiry. During our review we obtained the 1985 and 1986 contractor evaluations. Information for 1987 was not available.

Evaluation results for 1985 and 1986 show that most carriers and intermediaries met the standard for responding to beneficiary inquiries. However, the percentage of intermediaries that met the standard decreased from 1985 to 1986. For carriers, the percentages remained about the same.

HCFA evaluated 61 intermediaries to determine if they met the 1985 timeliness standard for written responses to inquiries. Of the 61 intermediaries, 57 (or 93 percent) met the standard. In 1986, HCFA evaluated 56 intermediaries, and 37 (66 percent) met the standard.

In the 1985 evaluations, HCFA also selected 49 carriers to determine if they met the timeliness standard for written responses to inquiries. Of the 49 carriers, 32 (or 65 percent) met the standard. In 1986, HCFA reviewed 47 carriers, of which 30 (64 percent) met the standard.

Beneficiary Telephone Service[9]

Carrier telephone service for Part B beneficiaries improved during 1987. HCFA was able to more accurately monitor carrier compliance with telephone response time standards because of telephone monitoring equipment funded in 1986.

In 1985 the Secretary of Health and Human Services and the Gray Panthers, a senior citizen advocacy group that had brought a suit against the Secretary, reached agreement that required carriers to improve Part B toll-free and local telephone service. According to a HCFA official and Gray Panther litigation information, carrier toll-free telephone service was deteriorating before the suit. HCFA officials acknowledged that the percentage of callers who received a busy signal when calling a carrier rose from 10 to 40 percent. Carriers were also responding to a smaller percentage of calls within 120 seconds.

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[9]Telephone service is not measured under Part A. Few beneficiaries call intermediaries since all Part A claims are assigned.

As a result of agreements reached between the Secretary and the Gray Panthers, HCFA set forth standards to help improve carrier telephone service. These standards included the following:

-- 20 percent or less of the callers will experience a busy signal.

-- 20-second telephone response time to acknowledge a call.

-- 120-second waiting time before a carrier representative talks with the caller.

HCFA incorporated the first and third standards into the 1986 contractor evaluations.

HCFA funded the cost of telephone monitoring equipment in 1986 to more accurately measure contractor compliance with the standards during 1987. In 1987, as part of its contractor evaluations, HCFA began monitoring carrier compliance with the 20-percent busy signal standard and 120-second waiting time standard. HCFA does not monitor carrier performance relating to the 20-second response time standard since the telephone answering equipment installed at the carriers automatically acknowledges calls within 20 seconds.

Telephone service reports prepared by HCFA show that by the end of calendar year 1987, nearly all carriers were meeting the 20-percent busy signal standard. The reports also show that carriers improved their performance in meeting the 120-second waiting time standard. In January 1987, 82 percent of toll-free callers and 80 percent of local callers were waiting no more than 120 seconds to speak to a carrier representative. By December 1987, these percentages had increased to 89 percent and 92 percent, respectively.

Beneficiary and Provider Appeals

Beneficiaries dissatisfied with a contractor's claim decision may appeal under either Part A or B. Under Part A, appeals are called reconsiderations; under Part B, they are called reviews. If still dissatisfied, and the claim is $100 or more, beneficiaries may appeal to an administrative law judge under Part A or a carrier-appointed hearings officer under Part B.

Beneficiaries requested an increasing number of reconsiderations and reviews from 1983 through 1987, and contractors correspondingly cleared an increasing number of such cases. Only under Part B, however, are data available on time

taken to process reviews and hear appeals, and they show carrier improvement during 1987 for the first time since 1983. In 1987, a smaller percentage of review cases and appeals were pending at year end than the year before for 60 days or more and 120 days or more, respectively.

Appeals Process

Beneficiaries who are dissatisfied with a contractor's initial claims decision may appeal. If the contractor's decision concerning basic entitlement to program benefits is appealed under either Part A or Part B, the beneficiary is entitled to a hearing before a Social Security Administration (SSA) administrative law judge. Procedures differ between Parts A and B for appealing payment amount decisions. Under Part A, if the beneficiary appeals such a decision, the intermediary makes a reconsideration determination, which may be appealed before an SSA administrative law judge if the amount in controversy is $100 or more. Under Part B, a beneficiary may appeal a carrier's claims denial or amount of payment decision and request a review by the carrier. If still dissatisfied after the review, the beneficiary may request a hearing before a carrier-appointed hearing officer when the amount in controversy is $100 or more.

Part A Reconsiderations and Part B Reviews Cleared

The number of Part A reconsiderations completed (cleared) remained relatively constant from 1983 through 1986, but more than doubled in 1987. This was primarily due to the fact that the number of HHA cases cleared during this year approximately tripled. Part B review requests received from 1983 through 1987 increased at an average annual rate of 33 percent.

Under Part A the number of reconsiderations cleared has increased at a much higher annual percentage increase than the rate at which intermediaries deny claims, while under Part B the averages for reviews cleared and claims denied by carriers have been about the same. More specifically, the number of Part A reconsiderations cleared by intermediaries from 1983 through 1987 increased at an annual average rate of about 136 percent, while the denial rate for claims increased at about a 69-percent annual average. Meanwhile, the number of Part B reviews cleared by carriers during this period increased at an annual average rate of almost 34 percent, while the number of claims denied increased at an annual average rate of about 37 percent.

The number of reconsiderations under Part A and review cases under Part B that were cleared in 1983 through 1987 are shown in figures 10 and 11. Figure 10 includes information on SNF and HHA reconsiderations, as they are the providers that appealed the most.

Figure 10: Part A Reconsideration Cases Cleared (1983-87)

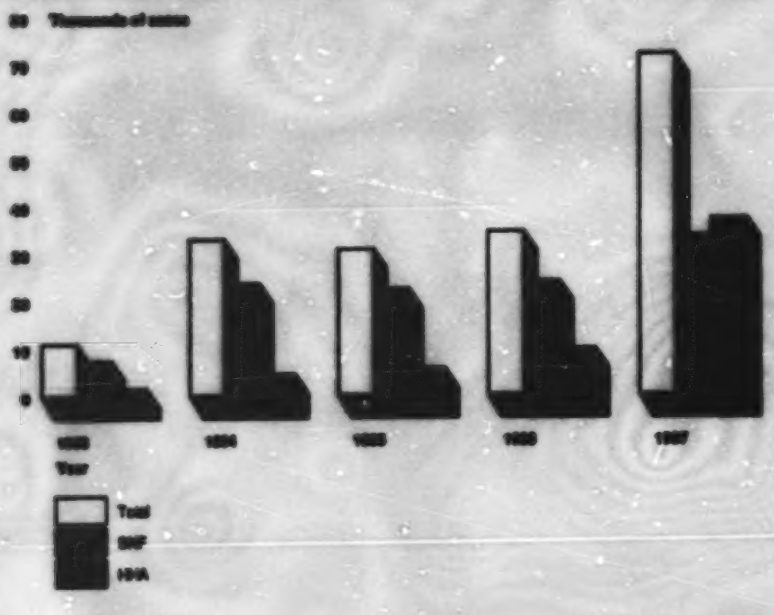
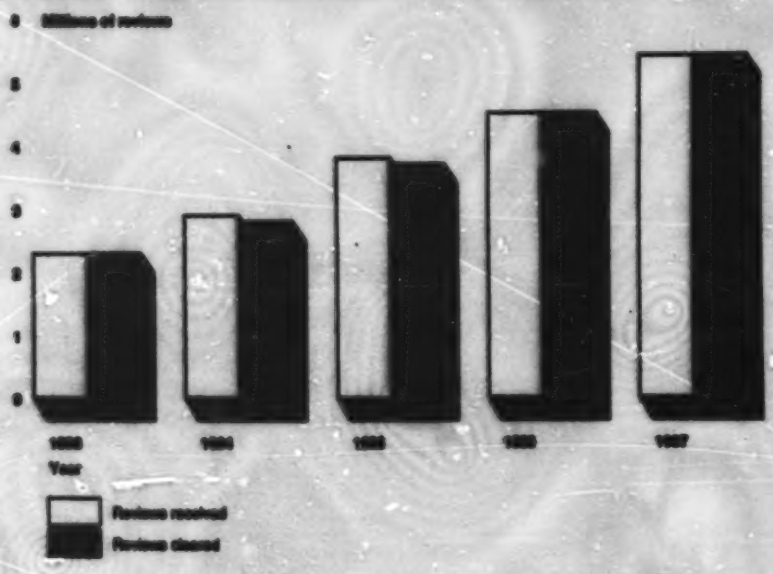


Figure 11: Part B Reviews Received and Cleared (1983-87)



The results of contractor reconsiderations and reviews as a percentage of total cases remained about the same. Figure 12 shows the percentage of Part A reconsideration cases affirmed,

reversed, and dismissed or withdrawn, while figure 13 shows the percentage of Part B review cases affirmed and reversed. Data on reconsideration cases for 1987 were not available.

Figure 12: Part A Results of Reconsideration Cases Cleared (1983-86)

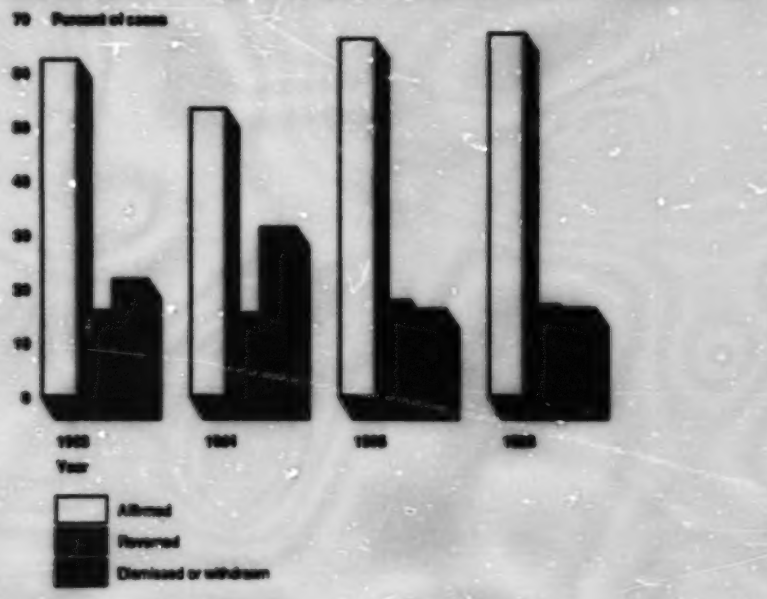
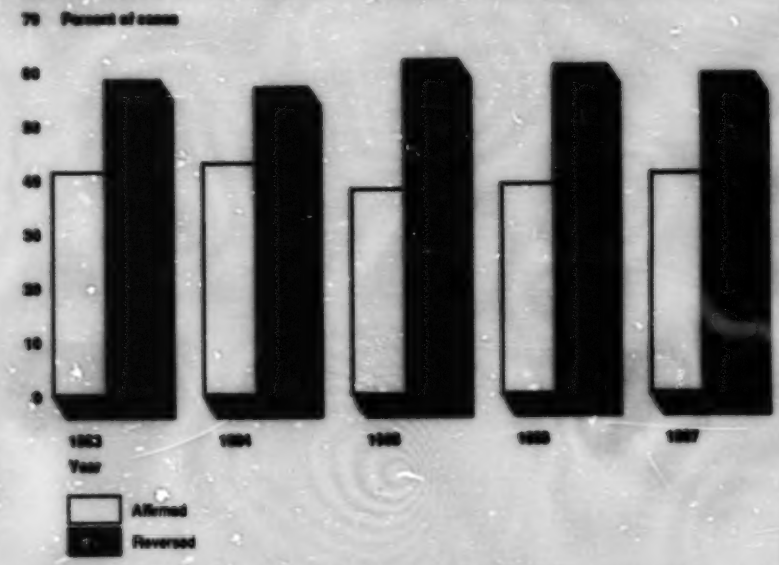


Figure 13: Part B Results of Review Cases Cleared (1983-87)

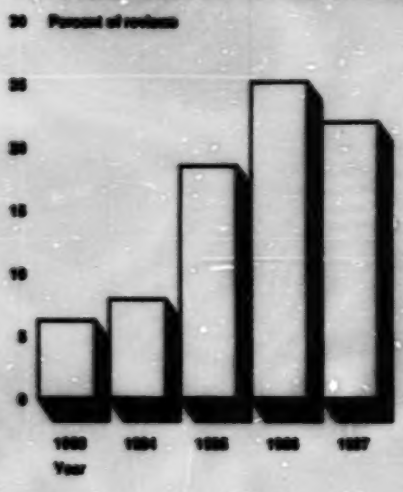


Note: Percentage of cases dismissed or withdrawn during these five years did not exceed 0.8 percent.

Part B Review Cases Pending

Carriers cleared an increasing number of Part B review cases from 1983 through 1987 and took, on average, longer to clear them. Figure 14 shows the percentage of reviews that had been pending for 60 days or more at the end of those years. Comparable information on Part A reconsiderations was not available.

Figure 14: Part B Percent of Review Cases Pending 60 Days or More (1983-87)

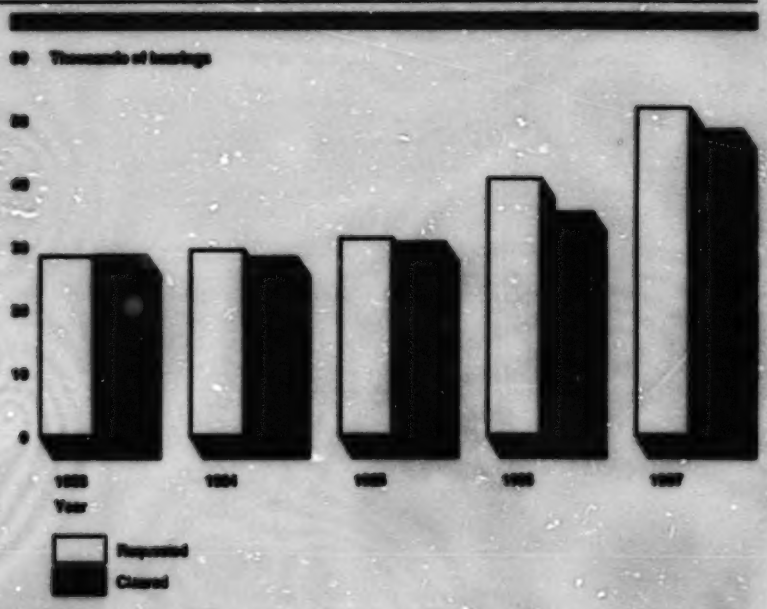


Quarterly data show that the percentage of reviews pending 60 days or more was lowest during the second quarter of 1983 (5.3 percent) and highest during the first quarter of 1987 (27.2 percent). At the end of 1987, the percentage had decreased to 21.9 percent.

Part B Hearings Cleared

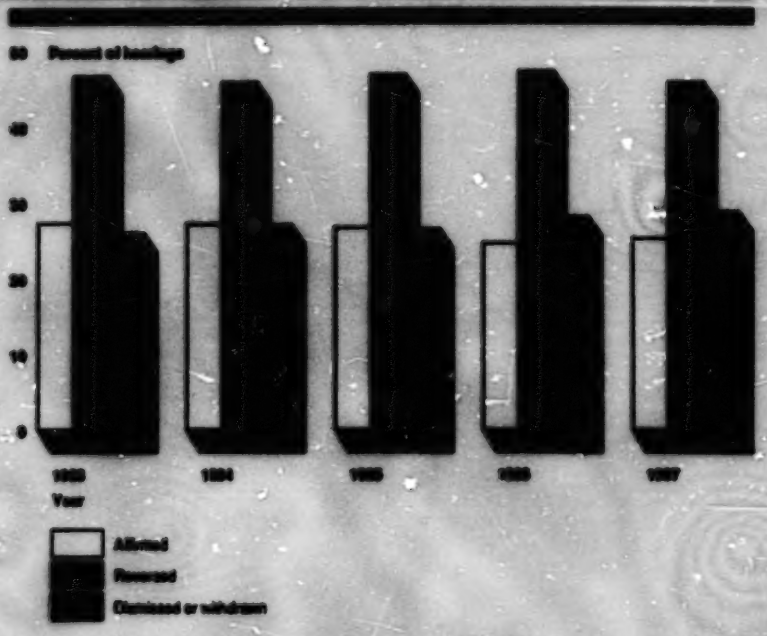
The number of Part B hearings requested and cleared was generally steady from 1983 through 1985 but increased in 1986 and 1987. The number of hearings requested and cleared in 1987 was almost twice that of 1983. Figure 15 shows the number of Part B hearings requested and cleared during the 5-year period. Similar information for Part A was not available.

Figure 16: Part B Hearings Requested and Cleared (1993-97)



As shown in figure 16, the percentage of Part B hearings cases affirmed, reversed, and dismissed or withdrawn has remained relatively constant during the 5 years covered by our review.

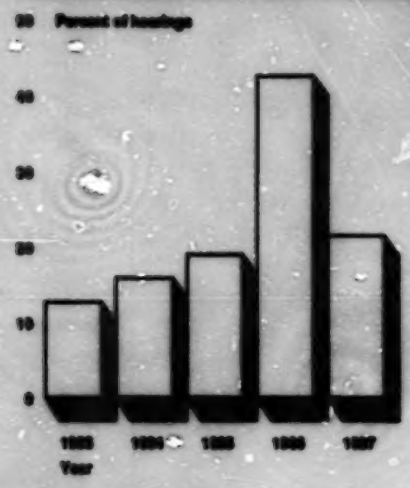
Figure 16: Part B Results of Hearings Cases Cleared (1993-97)



Part B Hearings Pending

The percentage of Part B hearings cases pending 120 days or more increased substantially between 1983 and 1986, as shown by figure 17. At the end of 1986, 42.6 percent of the hearings cases were pending 120 days or more; however, by the end of 1987, this figure had been almost halved to 21.5 percent.

Figure 17: Part B Percent of Hearings Pending 120 Days or More (1983-87)



Program Education Efforts

Contractor and HCFA officials and organizations representing the elderly and providers agreed that program education efforts had deteriorated over the past few years. They attribute the deterioration to funding limitations within the claims processing budget. These same officials and organizations believe that more education is needed due to the growing complexity of the Medicare program.

Public education efforts are conducted by Medicare contractors, who are expected to serve as a communications channel between the federal government and the beneficiary and provider communities concerning the program.

Contractor officials, HCFA officials, and the elderly and provider groups agreed that education increases the number of beneficiaries and providers who know, for instance, what services are covered under Medicare and what information is needed when submitting a claim. According to officials at the 12 contractors contacted, improving beneficiary and provider knowledge about the program can reduce the number of contractor requests for

additional information, beneficiary and provider inquiries, and contractor error rates.

With one exception, officials at the six intermediaries and carriers interviewed said that their public education efforts deteriorated from 1983 through 1987. Examples they cited included giving fewer workshops, reducing travel costs related to educational efforts, producing fewer bulletins about Medicare generally and program changes specifically, and reducing or eliminating their professional relations staff.

Officials at the one contractor whose public education efforts had not deteriorated during the 5-year period stated that they were able to significantly reduce the number of claims pending primarily because of their educational efforts with their provider community concerning proper billing procedures. Another contractor found that a non-clean claim cost them two to three times more to process than a clean claim; and is now conducting a campaign to better educate beneficiaries and providers to increase the percentage of clean claims.

Contractor officials were unanimous in citing funding limitations as the main reason for reduced program education. Since the cost of such education is included in contractor claims processing costs, officials said that little money is left after the funds budgeted for claims processing are used.

HCFA officials agreed that education efforts had deteriorated in the past few years. There was a general recognition that, in a time of budget constraints, beneficiary and provider services, such as education efforts, are one of the first areas of the Medicare program to be cut. HCFA officials generally agreed that because of insufficient funds, contractors no longer have enough professional staff to educate beneficiaries and providers about Medicare. HCFA officials also noted that about 80 percent of program communication services to beneficiaries is provided by SSA field office representatives. HCFA officials also stated that HCFA no longer regularly prepares or distributes educational materials to beneficiaries and providers because of budget limitations. They noted, however, that in April 1987 HCFA began to mail a booklet on the program to new enrollees. They also stated that HCFA requested $9.3 million in its 1989 budget request for carrier public relations efforts. These represent new funds for carriers to provide program education.

Elderly and provider group representatives agreed that public education efforts have generally declined during the 5 years covered by our review. Many were concerned that the gap is widening between the level of education needed and that provided and that the growing complexity of the Medicare program calls for greater education efforts, not less.

SUMMARY

Claims processing times improved in 1987 after increasing each year since 1983; however, they are still generally above 1983 levels. Whether the improved performance will continue into 1988 is uncertain.

Although the reasons for the improved fiscal year 1987 performance varies, the principal reasons for decreased claims processing times and accordingly the reduced number of pending claims at year end stems from OBRA requirements, HCFA's increased emphasis on processing times during its contractor evaluations, and increased funding. Likewise, improvements in beneficiary telephone service have resulted from HCFA emphasis on this service during evaluations of carrier performance.

The 1986 increase in claims processing accuracy is encouraging. However, whether 1987 data will show similar improvement in light of the increased number of claims and decreased processing times remains to be seen.

Contractor responsiveness generally to inquiries was slightly better in 1987. Although a significantly smaller percentage of intermediaries in 1987 were able to respond timely in writing, carrier telephone services improved during calendar year 1987.

Carrier processing of reviews and hearings improved during 1987 for the first time since 1983. In 1987, a smaller percentage of review cases and appeals were pending at year end than the year before for 60 days or more and 120 days or more, respectively.

Program education continued its decline through 1987. Although HCFA has taken action to inform new Medicare enrollees about the program, officials and groups involved in the program believe that increased attention should be devoted to program educational efforts. The one contractor who did not reduce its educational efforts believes that some of these efforts can be cost effective.

LIST OF ORGANIZATIONS CONTACTED

Contractors

Part A Intermediaries

Blue Cross and Blue Shield of Alabama

Blue Cross of California

Blue Cross and Blue Shield of Florida, Inc.

Blue Cross of Kansas

Blue Cross and Blue Shield of South Carolina

Prudential Insurance Company of America

Part B Carriers

Blue Cross and Blue Shield of Alabama

Blue Shield of California

Blue Cross and Blue Shield of Florida, Inc.

Blue Shield of Kansas City

Blue Cross and Blue Shield of South Carolina

Prudential Insurance Company of America

Organizations

Representing the Elderly

American Association of Retired Persons

Center for Medical Advocacy, Inc.

Institute for Health and Aging, University of California

Legal Assistance to Medicare Patients

Legal Services for the Elderly, Inc.

Patient Advocacy Committee

United Senior Citizen Health Cooperative

Representing Providers

American Hospital Association

American Medical Association

American Society of Internal Medicine

Healthcare Financial Management Association

National Association for Home Care

National Association of Rehabilitation Facilities

Society of Professional Benefit Administrators

Washington Council, American Academy of Physical Medicine and Rehabilitation

APPENDIX II

VALIDATION OF PART B CARRIER REPORTED CLAIMS PROCESSING TIMES

We verified the claims processing times that Blue Shield of Massachusetts (BSM) reported to HCFA for its Medicare part B operations in Maine, New Hampshire, and Vermont. We undertook a two-stage process to verify the accuracy of this information. We first tested BSM's internal reporting system to determine if its reports accurately summarize the claims processing times. We determined the way that BSM's processing subcontractor, Electronic Data Systems, develops statistics on claims processing times. We wrote our own computer program and processed the claims data for December 1986 to determine if we could replicate BSM's results. We found that BSM's reports to HCFA accurately summarized the claims processing information contained in its system for December 1986.

Secondly, we identified the universe of Medicare providers who accepted assignment and submitted 50 or more claims to BSM during calendar year 1986. This universe consisted of 2,660 providers who submitted about 99 percent of all assigned claims for that year. We contacted a statistically valid random sample of providers in Maine, New Hampshire, and Vermont and asked them, for the 30-day period from September 14 through October 13, 1987, to send us copies of all their assigned claims as they submit the originals to BSM.

A total of 56 providers participated in our sampling effort and submitted a total of 5,320 claims to us during the 30-day period under review. From those claims we selected a statistically valid random sample of 977 and determined how many were processed in 30 days or less from the time that BSM received them.

Based on our sampling effort, we are 95 percent confident that 97.48 percent (+/- 1.35 percent) of all assigned claims that providers submitted to BSM during that 30-day period were processed in 30 days or less. Most claims in our sample were processed by BSM from September through November 1987, and we found that the average processing time for these 977 claims was 8.8 days. Our results compare favorably to BSM's reported claims processing times for September, October, and November 1987. Over the 3-month period, BSM reported to HCFA that it processed 94.9 percent of its assigned claims in 30 days or less.

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